

STATE RESPONSES TO MEDICAID ESTATE PLANNING

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CHAPTER 1

INTRODUCTION

Medicaid estate planning is a process by which elderly people, often with the counsel of attorneys with special expertise in Medicaid eligibility rules, divest and/or shelter their income and assets in order to qualify for Medicaid coverage in nursing homes. The goal of Medicaid estate planning is to preserve assets, to the extent possible, while on paper, becoming "poor enough" to qualify for Medicaid. Rather than use one's own private resources to pay for nursing home care, the goal of Medicaid estate planning is to protect private resources and have public tax dollars pay for one's nursing home care instead under the Medicaid program.

Asset transfers to obtain Medicaid coverage have been a policy issue for many years in the Medicaid program, and there have been a number of policy responses to restrict their practice. In 1980, Congress first enacted the Boren-Long amendments, which denied SSI eligibility (and therefore Medicaid eligibility) to persons who transferred "countable" assets for less than fair market value. At their option, states could also deny eligibility to persons only applying for Medicaid coverage and who had disposed of assets in order to qualify. In 1982, transfer of asset provisions were extended to persons who transferred certain "excluded" assets, such as a personal residence. Although equity in a personal residence is generally not counted in determining eligibility for Medicaid, the transfer of equity in a home prevents states from eventually recovering incurred Medicaid costs from the estates of Medicaid recipients upon their death.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 made further amendments to Medicaid transfer of asset rules. First, it terminated transfer of asset prohibitions for individuals applying for SSI and/or Medicaid outside of institutions. Second, it required that all states adopt transfer of asset restrictions for nursing home recipients, rather than having these restrictions be optional. Third, it extended restrictions to all transfers made within 30 months of application for Medicaid, instead of 24 months. Fourth, in conjunction with new Medicaid eligibility rules for married couples, it allowed unlimited transfers to occur between Medicaid applicants and their spouses (since under the new rules, the combined resources of a married couple are counted in determining Medicaid eligibility for the institutionalized spouse). Other modifications to transfer of asset rules were also made under MCCA.

Despite these efforts by Congress to restrict the practice of Medicaid estate planning, state Medicaid programs report that Medicaid estate planning activity has increased substantially in recent years. Factors which have contributed to this growth in activity include the following:

- The overall wealth of the elderly population has increased markedly over the last decade. In turn, this has exposed a growing number elderly people to the risk of significant financial loss in the event they need nursing home care.
- The cost of privately-financed nursing home care has also increased significantly, and is estimated to average about \$32,000 annually in 1993. In certain metropolitan areas, such as New York City, private nursing home costs are as high as \$75,000 per year.
- There has been significant growth in the "business" of Medicaid estate planning within the legal industry, such that there are now many attorneys who do nothing but Medicaid estate planning for elderly individuals.¹
- Concomitantly, there has been a dramatic expansion in knowledge and techniques in the Medicaid estate planning industry on how to make the assets and income of prospective Medicaid applicants "unavailable" during the Medicaid eligibility process.
- The Medicare Catastrophic Coverage Act of 1988, while mandating that all states adopt transfer of asset restrictions, also created a number of eligibility "loopholes" that Medicaid estate planning attorneys have successfully exploited.
- There has been slow development of other financial mechanisms, such as private long-term care insurance, which the elderly can use to protect themselves from the potential catastrophic costs of long-term care. Without alternative mechanisms, Medicaid estate planning often becomes the most attractive option to elderly persons for protecting their accumulated lifetime savings.

The growth in Medicaid estate planning activity in recent years coincides with increasing fiscal constraints on the capacity of states to finance the Medicaid program.² In this context, states are becoming more aggressive in their efforts to ensure that limited Medicaid resources are used to assist elderly people who truly cannot afford to pay for their own nursing home care.

This report describes recent efforts by states to address the problem of Medicaid estate planning within the constraints of Federal law. Although Federal law provides the fundamental ground rules on state Medicaid eligibility policy, including how Medicaid transfer of asset penalties should be applied, states still exercise some discretion over the interpretation of Federal laws and regulations, and in the administration of these policies.

In addition, since Medicaid estate planning often involves exploitation of the more "arcane" provisions of Medicaid eligibility policy, often there is disagreement between states and the Medicaid estate planning "industry" over the interpretation of Federal law, as this report highlights. Occasionally, these disagreements over the interpretation of Federal law are disputed in the courts.

¹Burwell, Brian. Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage. Report prepared by SysteMetrics for the Health Insurance Association of America, September 1991.

²The Kaiser Commission on the Future of Medicaid. Medicaid at the Crossroads. November 1992.

The information presented in this report was collected primarily through phone interviews with key informants in various states. Time and resource constraints prevented a more systematic data collection effort. However, interviews were held with individuals in 31 different states, including every state in which there was some indication that Medicaid estate planning was being addressed through new policies. In those states where initiatives were underway, copies of recent legislation, regulation, task force reports, internal memoranda, and other documents were requested and reviewed. The purpose of the report is to provide readers with an overview of recent state initiatives in this area.

Readers are forewarned that at the time of this writing, May 1993, there was a significant level of activity among states on this issue, including new legislation that had been recently enacted in some states and additional legislative proposals that were under serious consideration in others. Thus, the information presented in this report on state policy responses to the problem of Medicaid estate planning may become quickly out of date.

To this date, there has been no empirical work which has tried to estimate the magnitude of Medicaid estate planning activity or its impact on state Medicaid expenditures. By its very nature, Medicaid estate planning is difficult to research. Medicaid applicants are required to report financial transactions in the 30-month period prior to applying for Medicaid, but are not required to report any transactions which may have occurred prior to this period. Applicants are also understandably reluctant to divulge the extent of their Medicaid estate planning activity prior to applying for Medicaid. Nonetheless, more empirical research on this issue is needed to inform the policy debate. In this regard, the Senate Finance Committee recently requested that the General Accounting Office conduct a review of Medicaid applications in the state of Massachusetts to assess the extent of Medicaid estate planning activity. The GAO's report is expected to be available in the summer of 1993.

CHAPTER 2

STATE RESPONSES TO MEDICAID ESTATE PLANNING

2.1 Task Forces, Commissions and Studies

The growth in the Medicaid estate planning industry is impacting state Medicaid budgets at a particularly difficult time. While the overall economy remains sluggish and state revenue growth has been peaked over the last few years, Medicaid outlays continue to escalate at a dramatic rate. From 1989 to 1992, aggregate Medicaid spending almost *doubled* from \$58.6 billion to \$113.3 billion, increasing at an *average* rate of 24.6% over this three-year period.³ In response to these escalating costs, states are placing ever-increasing scrutiny on their Medicaid budgets, looking for every opportunity to contain the rise in Medicaid spending. As a consequence of this scrutiny, the budgetary impact of Medicaid estate planning is becoming a more visible political issue, and in many states, initiatives to close Medicaid eligibility loopholes are being conducted in the context of overall Medicaid cost containment initiatives.

In 1992, one of the most ambitious initiatives took place in the state of **Virginia**. The Virginia General Assembly directed its Joint Legislative Audit and Review Commission (JLARC) to conduct a comprehensive analysis of Medicaid-financed long-term care services, and to develop legislative recommendations that would help to improve the efficiency and effectiveness of long-term care services financed under Medicaid. As part of its review, the General Assembly directed the JLARC to determine the extent to which Medicaid applicants were using asset transfers to qualify for nursing home benefits.

The JLARC conducted a comprehensive analysis of Medicaid estate planning activity in Virginia. JLARC staff interviewed eligibility workers in 14 of the state's 124 local social service offices which process applications for Medicaid, reviewed the applications of a sample of 510 new Medicaid admissions to nursing homes, checked property records for each of the 510 persons in the study sample, and conducted a computer match of all Medicaid long-term care recipients in 1991 with five years of state income tax data on these recipients from 1986 through 1990.

³Source: HCFA 64 data, Office of State Agency Financing Management, HCFA.

The JLARC presented its findings to the General Assembly in November 1992.⁴ The Commission estimated that \$14 million in assets were being protected through the use of Medicaid loopholes, and that in addition, the state could recover \$9.7 million annually if it implemented a proactive estate recovery program. These savings represented about 7.6% of total Medicaid spending for nursing home care in Virginia in 1991.

As a result of the JLARC's findings, four legislative proposals were drafted for the 1993 session of the Virginia General Assembly, and were introduced in January 1993. These four bills proposed to:

- Require the Department of Medical Assistance to implement an estate recovery program;
- Give the Department of Medical Assistance authority to attach liens to the property of Institutionalized Medicaid recipients;
- Void exculpatory clauses in Medicaid planning trusts which render trust principal and/or income unavailable to the creator or the creator's spouse in the event of application for Medicaid;
- Limit the use of term life insurance policies as a divestiture strategy; and
- Memorialize Congress to pass legislation to further close Medicaid eligibility loopholes and restrict the use of asset transfers.

All four bills were approved by the Virginia General Assembly without extensive debate in February 1993, and will go into effect on July 1, 1993.

Also in 1992, a bipartisan task force in Wisconsin identified Medicaid estate planning as a significant policy problem in the Medicaid program, and recommended that the state enact legislation to tighten eligibility loopholes. The Health Care Cost Containment Task Force recommended that legislation be enacted to:

- Treat withdrawals from joint bank accounts as prohibited transfers;
- Limit the use of trusts to shelter available assets;
- Treat the purchase of irrevocable annuities as a prohibited transfer in specified cases; and
- Treat multiple transfers as a single transfer.⁵

These recommendations were incorporated into the Governor's FY 1993-1995 budget, and have been drafted into specific legislative proposals for consideration by the Wisconsin General Assembly. Voting on these bills will probably occur in July of 1993, and if enacted, would go into effect on October 1, 1993.

⁴Medicaid Assets Transfers and Estate Recovery, Joint Legislative Audit and Review Commission, Virginia General Assembly, November 1992.

⁵"Medicaid Loopholes May Close." Milwaukee Sentinel, January 20, 1993.

The Indiana Commission on State Health Policy also recently recommended a series of legislative and administrative changes to address the Medicaid estate planning problem in that state.⁶ These recommended changes included:

- Require the Office of Medicaid Policy and Planning to improve state verification of property and transfers;
- Enact a new statute to treat multiple divestments consecutively;
- Enact a new statute authorizing the placement of liens on the property of Medicaid recipients;
- Enact a new statute requiring specific enhancements to the state's estate recovery program; and
- Advocate that the Indiana Congressional Delegation amend Federal Medicaid statutes to enhance estate recovery programs and close eligibility loopholes.

As a result of these recommendations, the current administration in Indiana has included provisions in its health care legislative package to make numerous changes to existing statutes governing the imposition of liens against the estates of Medicaid recipients, to prohibit trust agreements and insurance plans from reducing or excluding coverage due to the beneficiary's receipt of Medicaid benefits, to require that the assets of a trust *must* be applied toward the cost of care for a Medicaid recipient who is a beneficiary of the trust, and to prohibit courts from approving income or resource allowances for the community spouses of institutionalized Medicaid recipients that are higher than allowed under the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act (MCCA). At the time of this writing, these provisions have been approved in the House version of the bill, and are currently under consideration in the Senate of the Indiana General Assembly. If enacted, these new provisions would go into effect on July 1, 1993.

In Illinois, the legislature has directed the state auditor's office to conduct a comprehensive review of the Department of Public Aid's procedures for identifying illegal property transfers among Medicaid applicants and recipients. This review is still in process. In addition, a Task Force within the Department of Public Aid is also examining options for tightening Medicaid loopholes, including the option of enacting an estate recovery program. The Task Force is scheduled to submit its recommendations to the Department in the spring of 1993.

In Utah, a Medicaid Lien Committee has been meeting periodically to examine the option of implementing a Medicaid lien authority in conjunction with the state's estate recovery program. Although the state already has the statutory authority to implement a lien authority under Medicaid, it does not currently exercise that authority. The Committee is also exploring the option of whether the state could implement a lien program that would allow some protection for heirs, such as exempting property below a certain threshold (e.g. \$50,000) from recovery.

⁶Indiana Commission on State Health Policy, Hoosier Health Reform: A Strategic Plan for Indiana's Future, Executive Summary, November 1992.

2.2 Limitations on the Home as an Exempt Resource

Whether or not a Medicaid applicant or recipient's home should be considered a countable asset in the determination of eligibility for Medicaid is one of the more controversial and politically-sensitive issues in Medicaid eligibility policy. On the one hand, equity in a home often constitutes the majority of an elderly individual's total net worth. The loss of a home can be emotionally devastating to someone who has worked his or her entire lifetime to obtain a mortgage-free residence, and who has a strong desire to bequeath the home to his or her heirs. On the other hand, exemption of the home as a countable resource in determining eligibility for Medicaid creates opportunities for Medicaid applicants and recipients to shelter significant amounts of assets in their homes, yet still receive public assistance for the cost of their nursing home care.

Although all states recognize that a Medicaid recipient's primary residence should remain an exempt resource as long as there is a reasonable likelihood that the recipient might be discharged from a nursing home and returned home, a key issue is whether the home should remain an exempt resource *when there is no chance that the recipient will ever be discharged*. The argument is made that if there is no chance that a nursing home recipient will ever return home, then the home is no longer that individual's "primary residence" and therefore should no longer be considered an exempt asset.

However, in states which follow SSI rules in determining eligibility for the aged, blind and disabled (often referred to as "1634" states), Federal Medicaid policy stipulates that the primary residence remains an exempt resource as long as the Medicaid recipient expresses an *intent to return home*. This is because "1634" states can be no more restrictive than the SSI program in determining whether or not a home is a countable asset. Therefore, SSI regulations governing the exclusion of the home *must* be adhered to in determining the eligibility of SSI-related Medicaid applicants and recipients. SSI regulations governing exclusion of the home when an individual leaves his or her home are fairly explicit:

"If an individual (and spouse, if any) moves out of his or her home *without the intent to return*, [emphasis added] the home becomes a countable resource because it is no longer the individual's principal place of residence." 20 CFR §416.1212(c)

The "intent to return" criterion was recently tested by the state of Massachusetts, which, in the fall of 1991, revised its Medicaid regulations to implement an "objective" standard in assessing an individual's intent to return home. The regulation required that all Medicaid recipients or applicants in nursing homes obtain a doctor's certification of their likelihood to return home within the following six months. If such a certification was not provided, then the applicant or recipient would be given nine months to sell the home. After nine months, the owner would be forced to accept any offer for the home above two-thirds of its assessed value.⁷

⁷"HCFA Rejects Mass. House-as-Assets Rules," *The ElderLaw Report*, Vol. III, Number 8, March 1992. As required under Federal law, this policy was not to be applied in cases where the recipient's spouse, a disabled child, a dependent relative, or a caretaker child was living in the house.

However, in December 1991, HCFA informed Massachusetts that this policy was not in compliance with Federal Medicaid law, because it was more restrictive than SSI policy, and as a "1634" State, Massachusetts' eligibility policy for Medicaid could be no more restrictive than SSI policy. HCFA ruled that "objective" standards of an individual's intent to return home could not be applied, since SSI policy accepts an individual's verbal statement of intent to return home as sufficient for maintaining exclusion of the home. HCFA pointed out that "[t]he Social Security Administration does not look behind the statement or at the person's medical condition." Thus, Massachusetts was forced to rescind its policy, and now requires only a verbal statement of intent to return home as sufficient for maintaining the exclusion of the home as a countable asset.

There are, however, 12 states which under Federal law may use more restrictive criteria in determining the Medicaid eligibility of aged, blind and disabled Medicaid applicants than are used in the SSI program. These are often referred to as "Section 209(B)" states, and they are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia. Several of these states, including Connecticut, Missouri, North Carolina, and Virginia do treat the home as a countable asset under some circumstances. It is important to note that "1634" states may switch to "209(B)" status any time they want, but in doing so, can only apply eligibility criteria which are no more restrictive than those that were in effect in the state on January 1, 1972, prior to the enactment of the SSI program.

Although, in most states, the primary residence remains an exempt resource throughout an individual's participation in the Medicaid program, states also have the means, at least theoretically, to ensure that home equity held by a Medicaid recipient is eventually used to recover costs incurred by the recipient while on the Medicaid program. Coordinated efforts, however, must be in place if state Medicaid programs are to eventually recover costs from real property held by Medicaid recipients.

First, a state must have an effective system for identifying real property held by Medicaid recipients at the point of application (and in the 30-month period prior to application) as well as a system for tracking the property throughout the recipient's enrollment in the program to ensure that it is not sold or otherwise divested without the state's knowledge. This can involve the use of secondary data sources, such as automated property tax records, to identify potential property held by Medicaid recipients, and to identify real estate transactions that may indicate that the property has been sold. It also involves tightening up loopholes used by Medicaid estate planning attorneys, such as revocable trusts, life estates, and joint tenancy agreements, the purpose of which is to ensure that property owned by recipients can be passed to heirs without being subject to Medicaid recovery through the probate process.⁸ For example, Massachusetts has recently changed its Medicaid application form to ask more proactive questions about where people lived prior to entering a nursing home, and what happened to the property if the applicant owned it. It is also being more aggressive about enforcing transfer of asset penalties when home property is transferred into trusts, life estates, and other sophisticated financial instruments without actually being sold.

⁸Dench, Bryan: "Medicaid Planning with Retained Life Interests." The ElderLaw Report, Volume IV, Number 6, January 1993.

Second, states must implement effective estate recovery programs which eventually recover Medicaid costs from property held by Medicaid recipients at the time of application (see Section 2.10). This includes pursuing claims on the estates of Medicaid recipients through liens or other mechanisms in instances where Federal law prohibits recoveries as long as a recipient's spouse, disabled child, dependent relative, or caretaker child is living in the house. Although these exemptions may postpone recovery, the state still retains the right to eventually recover its costs over the long term.

2.3 Transfers Conducted Through Joint Bank Accounts

In many states, one of the easiest and most effective Medicaid estate planning strategies is to transfer assets through joint bank accounts. Under current Medicaid law, transfers made through joint bank accounts are not considered transfers for less than fair market value. The problem relates to the fact that these types of transfers generally involve a two-step process, *neither of which, in and of itself, can technically be treated as an asset transfer*. Consider the following example:

On February 1, 1993, Mrs. Anderson, a nursing home resident, adds her daughter, Donna Anderson, as a joint tenant on her savings account, which has a balance of \$100,000. On February 2, Donna withdraws all of the funds from the joint account, and places it in her own account. On February 3, Mrs. Anderson, who has no other significant assets, applies for Medicaid.

Medicaid transfer of asset rules dictate that penalty periods are to be applied when a Medicaid applicant or recipient transfers assets for less than fair market value to someone other than a spouse. Note that, technically speaking, *neither* of the transactions occurring on February 1 and February 2 in the above example meet this definition. The addition of Donna Anderson as a joint tenant on her mother's account on February 1 is technically not an illegal transfer because Mrs. Anderson still retains full ownership control over the entire \$100,000, with full rights of withdrawal, and thus there is no loss of fair market value to Mrs. Anderson. The transaction on February 2 is not an illegal transfer because Mrs. Anderson herself did not make the transfer. Donna withdrew the funds on her own volition, as she had every right to do, as a joint tenant to the account.

This divestiture "sleight of hand" is permitted to occur without the application of a penalty period because most State banking laws recognize that all tenants in a joint account have full ownership rights to the entire account. So, for the brief time when both Mrs. Anderson and her daughter are joint tenants on the account, they both are considered to "own" the full \$100,000.

Yet, it cannot be denied that between January 31 and February 3, a transfer of \$100,000 from Mrs. Anderson to her daughter took place. The fact that the transfer was conducted through a two-step transaction is irrelevant; the net result is the same as if Mrs. Anderson had given the \$100,000 to her

daughter outright. It would seem to be entirely appropriate for states to apply periods of ineligibility when such step transactions are identified.⁹

But many states do not do so, because they believe that Federal Medicaid law does not permit them to apply penalty periods to these types of transactions. Medicaid estate planning attorneys have similarly argued that such transactions should not be treated as disqualifying transfers, based upon SSI policy regarding the treatment of funds in joint bank accounts for SSI applicants.¹⁰ However, it is necessary to note that the Medicare Catastrophic Coverage Act terminated all transfer of asset provisions for SSI applicants, while expanding transfer of asset restrictions for Medicaid applicants. Nonetheless, to this date, Federal laws governing Medicaid eligibility policy have not specifically addressed the application of transfer of asset provisions to withdrawals from joint bank accounts.

On the assumption that transfer of asset penalties *cannot* be applied to withdrawals by non-applicants from joint accounts, in 1992 the state of **Michigan** applied for and received a waiver from HCFA to treat such transactions as illegal transfers on a demonstration basis. This demonstration began April 1, 1993 and will extend through September 30, 1997.

Other states, however, have interpreted Federal law as allowing states to apply transfer of asset penalties to withdrawals from joint accounts by non-applicants, and have clarified their interpretations in state Medicaid regulations. For example, effective May 15, 1992, the state of **Maryland** issued its own regulations regarding the treatment of resources in joint bank accounts, and withdrawals from joint bank accounts made by non-applicant owners. The regulations stipulate that at the time of application, all of the funds in a joint bank account are presumed to belong to the applicant unless the applicant can prove, through rebuttal, that he is not the full owner of the funds. In addition, any withdrawal from a joint account by a non-applicant is treated as an illegal transfer unless the non-applicant can demonstrate that the withdrawn funds actually belong to him.¹¹ Similarly, Florida is revising its Medicaid regulations to clarify that the creation of joint accounts, and the subsequent withdrawal of funds from the account by non-applicants, will be treated as illegal transfers subject to penalties.

⁹Admittedly, it is not so unequivocal when each step of this two-step transaction occurs at vastly different times. For example, consider the possibility that Donna's name was added to the account more than 30 months prior to Mrs. Anderson's application for Medicaid, but Donna's withdrawal of the funds occurred on the day prior her mother's Medicaid application. Should this transaction be treated as an illegal transfer, or should the fact that Donna had been a joint tenant on the account for more than 30 months mean that it should be treated as an exempt transfer?

¹⁰National data on state Medicaid eligibility policy on this issue are not available. One estate planning attorney reports that these types of transactions are not treated as disqualifying transfers in Arizona, Florida, Maine and Wisconsin. See Gordon, Craig: "The Effect of Jointly Owned Assets on Medicaid Eligibility." Presentation at seminar on Sophisticated Medicaid Planning and New Developments in Income Cap States: A Panel Discussion, Second Annual Elder Law Institute, Chicago, Illinois, November 13-15, 1992.

¹¹COMAR 10.09.24 Medical Assistance Eligibility, .08 Consideration of Resources, J. Treatment of Joint Accounts.

Although Arizona does not treat withdrawals from a joint bank account by a non-applicant as a transfer of assets, it does deem a transfer to have taken place on the date the joint account was established.¹² Virginia considers that one-half of the assets in a joint bank account belong to the owner, and therefore applies transfer of asset penalties if non-applicant co-owners withdraw over half of the assets in the account (unless the non-applicant can prove prior ownership of the withdrawn assets). As previously discussed, the Wisconsin General Assembly is presently considering legislation that would treat withdrawals from joint accounts, in excess of funds originally contributed by non-applicants, as prohibited transfers.

2.4 Restrictions on Multiple Transfers Designed to Incur Concurrent Penalty Periods

The Medicare Catastrophic Coverage Act (MCCA), while requiring all states to impose penalties on Medicaid applicants who dispose of countable resources within 30 months of application, also contained various "loopholes" which have been exploited by Medicaid applicants and their attorneys. One of the largest of these loopholes is the MCCA provision that *"the period of ineligibility shall begin with the month in which such resources were transferred..."* This provision creates the opportunity for Medicaid applicants to transfer their assets in sequential months, such that applied periods of ineligibility run concurrently from the date of each individual transfer, rather than consecutively. Creating concurrent, rather than consecutive, penalty periods drastically reduces the impact of transfer of asset restrictions on people who have made multiple transfers of assets in the 30-month period prior to Medicaid application. The following example, drawn from an actual case presented by a Medicaid planning attorney, illustrates the impact of this loophole.

Exhibit 1

The Effect of Imposing Concurrent Periods of Medicaid Eligibility

Mr. Anderson (not the client's real name) was a resident of a nursing home in a large metropolitan city who applied for Medicaid coverage in August 1992. Mr. Anderson submitted a copy of his bank account transaction statements, showing an \$80,000 withdrawal as a gift to his son in January 1991. The penalty period for this transfer was calculated to be 15.63 months (the average private pay rate in the city was \$5,116 per month). This penalty period therefore expired in April 1992. Mr. Anderson made another prohibited transfer to his son of \$50,000 in July of 1991. The penalty period for this transfer was calculated to be 9.77 months, and therefore expired in May 1992. In August of 1991, Mr. Anderson made a third prohibited transfer of \$30,000 to his grandson. The penalty period for this transfer was calculated to be 5.86 months, which expired in February 1992. Thus, Mr. Anderson's was granted eligibility for Medicaid immediately upon application, although he had transferred a total of \$160,000 within the last 20 months. If these transfers had been treated consecutively rather than concurrently, Mr. Anderson would have been subject to the maximum penalty period of 30 months ($\$160,000 / \$5,116 = 31.3$ months) from the date of the original transfer (January 1991). If treated consecutively, Mr. Anderson would not have been eligible for Medicaid until July of 1993, 11 months after he was granted Medicaid eligibility when penalty periods were applied concurrently.¹³

¹²Gordon, Craig: "The Effect of Jointly Owned Assets on Medicaid Eligibility."

¹³Fatoullah, Ellice. "Transfer of Assets by the Individual and the Individual's Spouse." Presentation at seminar on Sophisticated Medicaid Planning and New Developments in Income Cap States: A Panel Discussion, Second Annual Elder Law Institute, Chicago, IL, November 13-15, 1992. This case also included the use of the "Just Say No" strategy (see Section 2.9) in which the community spouse claimed that she needed to keep another \$110,000 in assets for her own support needs.

Although the statutory language of MCCA was not specific on whether transfer of asset penalty periods could be imposed consecutively ("stacked") rather than concurrently, HCFA has supported this interpretation of the law. In October 1990, it circulated a Medicaid State Operations Letter to state Medicaid programs stating:

"This is in clarification of the method to be used in determining the period of ineligibility for persons who transfer resources without receiving fair market value more than once during a 30-month period. The question is whether such periods should be treated separately and any periods of ineligibility run concurrently or should they be treated as one transfer.

Pending publication of transfer of resource regulations States are free to adopt reasonable interpretations of the transfer statute in terms of how to treat multiple transfers. However, although the concurrent approach is a reasonable one, there is potential for 'gaming,' that is, the concurrent periods have the potential of eliminating the connection between the amount of the transfer and the size of the penalty....A State could regard any transfer that an individual could have made in one step, but instead chose to make into two or more steps during a period when the individual would be subject to restricted coverage, as being in fact a single transfer."¹⁴

Given these interpretive guidelines from HCFA, a growing number of states appear to be adopting the policy of "stacking" multiple transfers. For example, Maryland issued new regulations effective August 31, 1992 that simply state:

"If a person disposes of a resource for less than fair market value while in a period of ineligibility for an earlier disposal, the later disposal is considered a part of the earlier disposal for purposes of computing the total period of ineligibility." COMAR 10.09.24.08(K)(2)

In October 1992, New York also issued regulations clarifying that multiple transfers occurring within the same penalty period should be treated as a single transfer, as long as it did not result in a shorter penalty period than if the transfers were treated separately.¹⁵ Legislation clarifying that multiple transfers are to be treated consecutively in computing penalty periods is also being considered in Wisconsin.

However, despite support from HCFA, many states still count multiple transfers concurrently rather than consecutively. In a survey of elder law attorneys in 28 states conducted in the fall of 1991, respondents indicated that only six states "stacked" multiple transfers (Arizona, California, Kansas, Montana, Nevada, and North Dakota), while in the remaining 21 states, the policy was to either treat multiple transfers concurrently, or respondents were unaware of what policy was employed.¹⁶

¹⁴Medicaid State Operations Letter #90-87, October 1990.

¹⁵New York State Department of Social Services, Transmittal 92 ADM-44 October 28, 1992.

¹⁶"Medicaid Survey Results: Still No Nationwide Standards." The ElderLaw Report, Volume III, Number 8, March 1992.

2.5 Other Initiatives to Limit Asset Divestitures

Numerous other techniques have used by applicants and their attorneys to divest assets without incurring a period of Medicaid ineligibility. As new techniques are identified and employed, states are trying to close loopholes, to the extent permissible under Federal law, through new laws and regulation. Some of the lesser known asset divestiture strategies, and recent state responses, include the following:

Transfers made by agents of Medicaid applicants. Federal law defines a disqualifying transfer as one made by the "individual or the individual's spouse." Consequently, many estate planning attorneys simply have agents (e.g. under power of attorney) make transfers on their clients' behalf, and then argue, often successfully, that penalty periods should not be applied to these types of transfers because they were not made directly by the "individual or the individual's spouse." Connecticut, under Public Act No. 92-233, has restricted these types of transfers by stipulating that any disposition of property made by a "guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse." The law also stipulates that court-ordered transfers will be treated as if they had been made by the Medicaid applicant.

Transfers of lump sum payments. Since Federal transfer of asset laws only apply to transfers of "resources," not to transfers of "income," some Medicaid applicants have been advised to transfer any lump sum payments, such as inheritances, *in the month in which they are received*, and to then claim that such transfers are not disqualifying transfers because they were transfers of income, not resources. Minnesota enacted legislation in 1992 clarifying that both transfers of income and assets for less than fair market value are considered prohibited transfers, including "inheritances, court settlements, and retroactive benefit payments."

Disclaimers. In some cases, Medicaid recipients in nursing homes may be named as beneficiaries of an estate, the receipt of which would make them ineligible for Medicaid until the assets received are depleted on private care. Since there is sometimes no real benefit to such individuals of receiving such inheritances, these individuals, with legal counsel, may "disclaim" their inheritance, so that some other person (e.g. a child) may benefit from the inheritance instead. Disclaimers are commonly used by individuals to avoid taxation. The issue of whether the disclaiming of inheritances by Medicaid recipients constitutes a transfer of resources has generally been fought in the courts, with conflicting results.¹⁷ However, several states have enacted specific statutes which prohibit disclaimers by public assistance recipients. These states include Florida, Louisiana, Connecticut, Massachusetts, New York, Minnesota and North Dakota.¹⁸

Payments for "Personal Care" Services. In some cases, Medicaid applicants have argued that transfers made to their children or others were not transfers for less than fair market value, but rather payments for personal care services rendered over an extended historical period. While acknowledging that children may receive compensation for the provision of personal care services to their parents, Minnesota enacted legislation stipulating that these payments cannot be made retroactively. A new 1992 law stipulates that

¹⁷See M. Garey Eakes: "Advanced Medicaid Planning in the 209(B) States." Presentation at seminar on Sophisticated Medicaid Planning And New Developments in Income Cap States: A Panel Discussion, Second Annual Elder Law Institute, Chicago, Illinois, November 13-15, 1992.

¹⁸Kruse, Clifton. "Discretionary Trusts: Insulating Discretionary Trust Assets for Elders and Incapacitated Persons from Consideration by Medicaid and Other Public Support Providers." Presentation at the 3rd Annual Symposium on Elder Law, Orlando, FL, May 15-18, 1991.

such payments will be considered prohibited transfers *"unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided."*

Limits on Irrevocable Funeral Contracts. Another divestiture strategy is to establish "irrevocable funeral contracts" with funeral homes in amounts in excess of the reasonable cost of a real funeral. Since these contracts are "irrevocable," once established, the funds are no longer available to the Medicaid applicant. However, once the Medicaid applicant dies and funeral expenses are paid, the contracts are written to specify that any remaining funds revert to the applicant's heirs. To limit the use of this strategy, some states are contemplating applying for Federal waivers to place limits on the amount of funds that can be placed in irrevocable funeral contracts.

Limitations on the Purchase of Term Life Insurance Policies. A simple but effective Medicaid estate planning strategy for divesting assets is for an individual to purchase a term life insurance policy, often through a lump sum premium. Term life insurance policies, with no cash surrender value, are not considered countable resources in the determination of eligibility for SSI benefits, and are also exempt in State Medicaid programs which follow SSI rules. Neither is the purchase of a term policy considered a disqualifying transfer in most states because the purchaser is considered to have received fair market value (a future benefit) for his or her money. However, the net effect of purchasing a term life insurance policy is very similar to an outright transfer to a prospective heir. Often the benefit to premium ratios of these types of policies are very low. For example, an 80-year-old man may have to pay \$95,000 to purchase a term life insurance policy with a death benefit of \$100,000, along with a stipulation that no benefits will be paid until at least two years from the date of purchase. In response to this strategy, the **Virginia General Assembly** enacted legislation in its current legislative session to count the resources used by Medicaid applicants to purchase term life insurance policies within 30 months of application that have benefit to premium ratios that are lower than an established threshold, to be determined by Department of Medical Assistance Services.

Extension of the Transfer of Asset "Look-Back" Period. Federal Medicaid law limits the application of penalty periods for disqualifying transfers to transfers made within 30 months of an individual's application for Medicaid. Transfers which occurred prior to this 30 month "look-back" period, no matter how large, are not subject to penalty. Consequently, many elder law attorneys inform their clients that "Federal policy is that you are required to pay for a maximum of 30 months of nursing home care, after which the government will pay the bill." Although this statement is a distortion of Federal policy, it is nonetheless true—no individual has a legal responsibility under current Medicaid law to pay for more than 30 months of care out of his or her own resources.

In many cases, individuals only seek legal assistance with Medicaid estate planning once they (or a family member) enters a nursing home. Often the first piece of advice which an elder law attorney will provide at this point is for the individual to immediately transfer all assets in excess of an amount sufficient to pay for 30 months of private care. Other Medicaid estate planning strategies can then be employed to shelter or divest the remaining amount without incurring a penalty period.

Some states would therefore like to extend the "look-back" period beyond 30 months. For example, Iowa, is currently in the process of writing a waiver application to HCFA to extend the transfer of asset look-back period to 60 months. The **Connecticut General Assembly** has also requested that the Connecticut Department of Income Maintenance submit a waiver proposal to the Federal government to extend the transfer of asset penalty period.

Other states, however, are not supportive of extending the penalty period beyond 30 months because they believe that the administrative burden of documenting all financial transactions of Medicaid applicants for

a five-year retrospective period to determine whether any prohibited transfers have occurred will cost more than any Medicaid savings that will be realized from this policy change.

Some states have suggested an alternative policy change of extending the *penalty* period beyond 30 months, while maintaining the 30-month limit on the "look back" period. Thus, if a prohibited transfer occurred, the period of ineligibility would be determined by the amount of the transfer *without limitation*, although all transfers occurring more than 30 months prior to Medicaid application would remain exempt from the application of penalties.

2.6 Limitations on Annuities

An annuity is a financial instrument which generally pays a fixed income stream over a defined period in return for an initial deposit of principal. For example, Mr. Anderson may purchase an annuity for \$50,000 which pays him a fixed income of \$420 per month for the rest of his life. Annuities are used as Medicaid estate planning tools because (a) it can be argued that the purchase of an annuity is not a prohibited transfer, since the purchaser has received "fair market value" for the transaction, and (b) annuities are a convenient mechanism for immediately converting assets to income.

A Medicaid applicant who purchases an irrevocable annuity that pays a fixed income over his remaining lifetime gets no real benefit from the transaction, because although the purchase may allow him to qualify for Medicaid sooner, the income from the annuity must still be applied to the cost of his nursing home care, such that in the end, he has not truly "sheltered" any of his assets from Medicaid. However, other types of annuities do effectively shelter or divest assets. For example, a couple may use their combined assets to purchase an annuity naming the community spouse as the annuitant. This can raise the income of the community spouse, while reducing the amount of assets potentially available to the institutionalized spouse to pay for his or her own care.¹⁹

Another strategy is to purchase an annuity with a "term certain."²⁰ This type of annuity agrees to pay an income stream for a specified period of time even though the annuitant may die before the end of that period. For example, an 80-year-old may buy an annuity that pays out an income stream over a 20-year period. If the annuitant dies before the 20 years is up, the remaining payments revert to a named beneficiary, for example, a son or daughter. Thus, these types of annuities are often used as mechanisms for transferring assets to children without incurring transfer of asset penalties.

Another approach is for the Medicaid applicant to purchase a "private annuity" from a child or other intended heir. This annuity does not have to be a "term certain" since the child can simply keep any remaining principal upon the annuitant's death.

¹⁹Note that this strategy has much the same effect as the "shift assets before income strategy" described in Section 9.0.

²⁰Bove, Alexander. Second Supplement to the Medicaid Planning Handbook, Ormond Sacker Press, Boston, MA, January 1992.

Finally, another strategy reported by estate planning attorneys is for the community spouse to purchase a "short-term annuity."²¹ After a short period, (i.e. after the institutionalized spouse establishes eligibility for Medicaid) the annuity pays a lump sum payment back to the annuitant. Since the MCCA spousal impoverishment rules state that once a couple's resources are divided at the initial assessment, that there can be no further reassessment of the couple's combined assets, this lump sum payment cannot be considered an available resource to the institutionalized spouse after he becomes eligible for Medicaid.

In response to these strategies, some states have tried to limit the use of annuities as Medicaid estate planning tools. A survey of elder law attorneys in selected states reported that three states—**Connecticut, Kansas, and Illinois**—treat all purchases of annuities as illegal transfers, on the basis that the applicant has converted an available asset to an unavailable asset. Other states, including **Massachusetts, Minnesota, New York, and Virginia**, apply transfer of asset penalties to that portion of an annuity that exceeds the value of the benefit that is likely to be returned to the annuitant over his or her remaining life expectancy, using life expectancy tables. For example, if a 90-year-old Medicaid applicant purchases a 20-year annuity, the value of the annuity that exceeds his or her estimated life expectancy is treated as a prohibited transfer. Legislation proposing this method of treating annuities is also being considered by **Wisconsin** in its current legislative session. The state of **Michigan** has also received a Federal waiver to treat the purchase of all irrevocable annuities as illegal transfers, subject to penalties.

2.7 Limitations on the Use of Trusts to Shelter Assets

Trusts are among the more esoteric tools used by the Medicaid estate planning industry for sheltering assets. Trust instruments are often preferred to the actual gifting of assets because, under various trust arrangements, individuals can retain greater control over how their assets, and asset income, will be distributed over their remaining lifetime, and upon their death.²² In contrast, once an asset is divested through a gift or transfer, it is lost forever.

In response to the growing use of trusts as a Medicaid estate planning device, Congress first enacted legislation under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, which defined a "Medicaid qualifying trust" and stipulated the conditions under which States must count income and/or principal from a trust as available to a Medicaid applicant. In brief, COBRA stipulated that if a trustee has discretion over how trust income and/or principal is to be distributed, then the maximum amount that *could* be made available to the Medicaid applicant must be counted for Medicaid eligibility purposes, regardless of whether the trustee chooses to distribute the amount or not. Further, if a trust is *revocable*, meaning that the trustee has the authority to terminate the trust and convert the trust principal back to liquid assets, then it must be counted as fully available to the Medicaid applicant.

²¹M. Garey Eakes: "Advanced Medicaid Issues in the 209(B) States." Presentation at the seminar on Sophisticated Medicaid Planning and New Developments in Income Cap States: A Panel Discussion, Second Annual Elder Law Institute, Chicago, IL, November 13-15, 1992.

²²Budish, Armond. "How to Use a Medicaid Trust to Protect Savings." In *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing Home Care*. Henry Holt and Company, Inc., New York, 1989.

The enactment of the COBRA legislation limiting trusts as Medicaid estate planning tools stimulated increasingly sophisticated trust instruments that allow individuals to retain control over their assets, and asset income, while rendering these same assets as "unavailable" in determining eligibility for Medicaid. Thus, some states have had to go beyond the Federal COBRA legislation to enact further restrictions on the use of trusts as Medicaid estate planning devices.

Three states—**New York, Minnesota, and Connecticut**—have recently enacted their own legislation to place additional restrictions on the use of trusts in Medicaid estate planning.²³ Of the three, New York's is the least restrictive, while Connecticut's is the most restrictive.

In early 1992, **New York** added Section 7-3.1(c) of the Estates, Powers and Trusts Law, limiting the use of so-called "trigger" trusts. These trusts are crafted to circumvent the provisions of the COBRA legislation by including language which terminates the trustee's discretion to make trust distributions to the individual once the individual has a need to apply for Medicaid. For example, many are written to make the trust irrevocable and non-discretionary by a "triggering" event such as a nursing home admission. In this manner, the individual retains control over the distribution of their wealth until the very point when they have a need to obtain Medicaid coverage for their nursing home costs.

The New York legislation deems such trust provisions to be against public policy, and therefore, null and void. It states:

"Any provision of a trust created on or after April 2, 1992 is void if it directly or indirectly limits, suspends, terminates, or diverts the principal, income, or beneficial interest of the grantor or grantor's spouse in the event that the grantor or grantor's spouse applies for MA [Medical Assistance] or requires medical care, without regard to the irrevocability of the trust or the purpose for which the trust was created."

The New York law also voids any provision in a trust which states that if the trust is *not* excluded from being counted as an available resource, the trust terminates and the principal in the trust is distributed outright to someone other than the beneficiary or the beneficiary's spouse. Given uncertainty about possible rulings of trust assets being determined available or unavailable for Medicaid eligibility purposes, some estate planning attorneys have written in such clauses as "fail-safe" provisions.

The **Minnesota** law (Minnesota Laws 1992, Chapter 513, Article 7, Section 129) is somewhat more far-reaching than the New York law. The Minnesota provision simply states:

"A provision in a trust created after July 1, 1992, purporting to make assets or income unavailable to a beneficiary if the beneficiary applies for or is determined eligible for public assistance or a public health care program is unenforceable."

²³Coughlin, Kenneth. "Here Come the Trustbusters: States Move to Restrict Medicaid Planning." *The ElderLaw Report*, Volume IV, Number 4, November 1992.

In addition to voiding "trigger" trusts, the wording of the Minnesota legislation was such that it could also be interpreted to void supplemental needs trusts. Supplemental needs trusts are carefully worded to specify that trust income can *only* be used to meet the "supplemental needs" of the trust beneficiary, over and above any public benefits to which the beneficiary may be otherwise entitled.²⁴ Since these trusts explicitly state that trust resources cannot be used in place of support provided by public assistance programs, the elder law industry has argued (with State Medicaid agencies and, when necessary, in the courts) that supplemental needs trusts cannot be considered an available resource in determining Medicaid eligibility. Court rulings on these issues have not been consistent, with some ruling in favor of excluding resources in supplemental needs trusts as available to Medicaid applicants, and others ruling that trust resources must be considered in determining Medicaid eligibility.

Following enactment of the Minnesota statute, opposition to the law was expressed by parents who had established supplemental needs trusts for their severely disabled children. These trusts have historically been used to purchase services and equipment (e.g. motorized wheelchairs) that are not covered under the Medicaid program. Consequently, in 1993, an amendment was enacted to the statute which clarifies that supplemental needs trusts are enforceable in instances where the trust has been established for a person with a disability who is under the age 64, and by someone who is *not* the trust beneficiary, the beneficiary's spouse, or anyone obligated to pay any sum to the trust beneficiary under the terms of a settlement agreement or judgment. The language of the amendment effectively limits enforceable supplemental needs trusts to trusts created by parents for their disabled children.

The Connecticut statute, Public Act No. 92-233, took effect October 1, 1992 and is the most far-reaching. Two provisions of the act address Medicaid trusts. Section 1 states:

"Any disposition of property made on behalf of an applicant or recipient or his spouse by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility."

This section tightens a loophole in the COBRA 1985 legislation which defined a "Medicaid qualifying trust" as a trust "established by the individual or the individual's spouse." To circumvent this provision, some attorneys have advised clients to first *transfer* their assets to their children (or someone else) who then in turn establish a trust on the beneficiary's behalf. Since the trust was not technically established by the Medicaid applicant or the applicant's spouse, attorneys then argue that the trust does not meet the definition of a "Medicaid qualifying trust" and is therefore exempt. Attorneys have also asked courts to establish trusts on their client's behalf, and then argued that the trusts are exempt from Medicaid. The Connecticut law

²⁴Kruse, Clifton: "Discretionary Trusts: Insulating Discretionary Trust Assets for Elders and Incapacitated Persons from Consideration by Medicaid and Other Public Support Providers." Presented at the 3rd Annual Symposium on Elder Law, National Academy of Elder Law Attorneys, Orlando, FL, May 1991.

treats these so-called "donor" trusts in the same manner as if they had been established by the Medicaid applicant himself.²⁵

Section 3 of Public Act No. 92-233 is the most far-reaching. It essentially terminates any inter vivos trust established for the purpose of qualifying the trust beneficiary for Medicaid. It states:

"Upon the application of a person, his conservator or legal representative or the department of Income maintenance, the superior court shall terminate an inter vivos trust established by a person or the person's spouse...The superior court shall order that the principal and any undistributed income shall be distributed to the settlor of the trust."

This second provision has two major implications. First, it terminates all inter vivos trusts regardless of whether they were established within 30 months of application for Medicaid, or prior to 30 months of application. Thus, even resources which have been transferred to a trust more than 30 months before Medicaid application are now considered available in determining eligibility for Medicaid. Secondly, the applicant obtains no benefit from incurring a period of ineligibility for a prohibited transfer prior to the date of Medicaid application, because all of the resources in the trust become available to the applicant at the point of Medicaid application. For example, consider the following example:

Mr. Anderson creates an inter vivos trust with a principal amount of \$50,000 on January 1, 1991. One year later, on January 1, 1992, he enters a nursing home and applies for Medicaid coverage. Prior to enactment of Connecticut Public Law 92-233, transfer of asset penalties were applied and his period of ineligibility was computed by dividing the amount of the transfer by the average monthly cost of nursing home care, let's say \$3,000. His penalty period was therefore 16.7 months ($\$50,000/\$3,000 = 16.7$). Because the penalty period began on the date of the transfer (January 1, 1991), Mr. Anderson would have been eligible for Medicaid in April of 1992 (16.7 months later). He, therefore, "lost" only about \$14,100 of the amount he originally transferred (the amount he had to pay for his own care between January 1, 1992 and the time that he became eligible for Medicaid). However, under the new statute, all of the \$50,000 which Mr. Anderson placed in the trust is considered immediately available, and he must spend virtually all of the \$50,000 for his own care before he will be eligible for Medicaid.

Other States are considering enacting similar legislation to restrict the use of trusts. New Jersey has had legislation since 1980 which limits trusts which are specifically devised as "supplemental needs" trusts for Medicaid beneficiaries. However, New Jersey has found that the statute was written too narrowly, since estate planning attorneys have simply been careful to avoid the use of the word "Medicaid" in trust language, and have substituted "public assistance," "medical assistance," or other terminology instead. The State is contemplating recommending legislation to broaden the applicability of trust restrictions. The Wisconsin General Assembly is presently considering a legislative proposal to restrict the use of trigger trusts and supplemental needs trusts. Florida is also revising its regulations to clarify that any exculpatory

²⁵Note that Section 1 is also applicable to more general transfer of asset cases, in which conservator's for an incompetent person have transferred assets and then argued that no period of ineligibility should apply, since the transfer was not made by the applicant directly.

clauses which limit the trustee's discretion to distribute benefits in a manner that would make the beneficiary ineligible for Medicaid are to be disregarded.

2.8 Limitations on Income Trusts

"Income trusts" are a mechanism by which Medicaid estate planning attorneys reduce the available income of Medicaid applicants in so-called "income cap" States, which limit Medicaid eligibility for nursing home coverage to individuals with available income below 300% of the Federal SSI benefit standard.²⁶ The federal court case of Miller v. Ibarra, 746 F.Supp. 19 (D.Colo 1990) recognized the validity of such trusts. The Miller case involved four elderly residents of nursing homes whose monthly income was in excess of the 300% income limit in Colorado, but below the private cost of nursing home care.²⁷ In a September 1990 decision, a U.S. District Court ruled that these four nursing home residents could use a trust to reduce their countable income below Colorado's eligibility level for Medicaid. Since this decision, "income trusts," also referred to as "Miller-type trusts," have been increasingly used by Medicaid estate planning attorneys as a mechanism for reducing their clients' incomes, so that they can qualify for Medicaid coverage in the 19 income cap states.

In response to the ruling in the Miller case, the Colorado legislature, in October 1991, enacted a new law, House Bill 91S2-1030 which reduced the impact of the Miller decision by establishing limits on the type of trusts which can be used as a means of qualifying an individual for Medicaid coverage. The limits imposed on income trusts by HB 1030 include the following:

- The trust must be approved by a state court, either a Colorado District Court or the Denver Probate Court.
- The beneficiary of the trust must be someone whose income falls into the so-called "Utah Gap," i.e. whose income is in excess of the 300% Medicaid income level but below the private cost of nursing home care.
- All of the beneficiary's income must be paid into the trust at the beginning of each month, and from that amount, \$1 less than the 300% Medicaid income level must be distributed to the beneficiary. This amount must be applied to the beneficiary's monthly cost of nursing home care. Medicaid then pays the balance between the resident's contribution and the approved Medicaid reimbursement rate for the facility in which the resident resides.²⁸

²⁶In 1993, the Federal SSI benefit standard for an aged individual is \$434 per month, and therefore 300% of the benefit standard in 1993 is \$1,302.

²⁷Individuals with incomes between the 300% SSI benefit standard and the private cost of nursing home care are often referred to as falling in the "Utah Gap," which is somewhat baffling given that Utah is not one of the 19 states which use the 300% income cap. These 19 states are Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Iowa, Louisiana, Nevada, New Jersey, New Mexico, Oklahoma, South Carolina, South Dakota, Tennessee, Texas and Wyoming.

²⁸From the amount distributed to the beneficiary, the beneficiary is also allowed to keep the monthly personal needs allowance, to divert income to a community spouse, if applicable, under the Medicaid spousal impoverishment provisions, and to buy other medically necessary non-Medicaid items as approved by the state Medicaid agency.

- Any money which accumulates in the trust, in excess of the monthly distribution to the beneficiary, during the beneficiary's lifetime, will be claimed by the Colorado Medicaid estate recovery program upon the beneficiary's death. This estate recovery program was also enacted as part of the same legislation.²⁹

Thus, HB 1030 represents a relatively sophisticated response by the state of Colorado to the increasingly sophisticated practices used by Medicaid estate planning attorneys, and their efforts to legitimize these practices through litigation in the judicial system. While accepting the court's ruling in the Miller case, the Colorado legislature moved relatively quickly to limit the fiscal impact of the decision on the state's Medicaid budget.

2.9 Limiting Strategies to Increase the Community Spouse Resource Allowance

The spousal impoverishment provisions of the Medicare Catastrophic Coverage Act (MCCA) of 1988 significantly increased the amount of income and resources which community spouses of institutionalized Medicaid recipients can retain. Under these provisions, the amount of *income* which the community spouse is allowed to retain is called the Minimum Monthly Maintenance Needs Allowance (MMMNA) and the amount of *assets* which the community spouse can keep is called the Community Spouse Resource Allowance (CSRA). The new Medicaid spousal impoverishment rules apply uniformly to all state Medicaid programs, although states still retain considerable discretion over MMMNA and CSRA levels, as discussed further below.

Under the MCCA spousal impoverishment rules, the CSRA is generally determined by dividing the total countable assets owned by both spouses in half at the point at which the institutionalized spouse is first admitted to a nursing home. The CSRA is subject to both a *minimum* and a *maximum* amount. Currently, the minimum (in February 1993) is \$14,148 and the maximum is \$70,740. At their option, states can also set the *minimum* CSRA to be retained by the community spouse anywhere between the minimum and the maximum established in Federal law.

Under the provisions governing the MMMNA, the community spouse must be allowed to retain a minimum of \$1,149 per month (150 percent of the Federal poverty level for a couple) and up to a maximum of \$1,769 per month, at the option of each state. If the community spouse's own income is below the MMMNA, some of the income of the institutionalized spouse can be diverted to the community spouse to bring the community spouse's income up to the MMMNA. Exhibit 2 provides an illustration of how the Medicaid spousal impoverishment rules would be applied in a hypothetical case.

²⁹This section was largely drawn from summary materials provided by the Colorado Department of Social Services. The author would like to thank Stephen McCormick of the Department for providing these materials.

Exhibit 2

Application of MCCA Spousal Impoverishment Rules in a Hypothetical Case

Mr. Anderson enters a nursing home on January 1, 1993. On that date, he and his wife have a total of \$220,000 in countable assets. On the day of his nursing home admission, Mr. and Mrs. Anderson's total assets are divided equally between them. However, because Mrs. Anderson's share (\$110,000) is above the maximum CSRA level of \$70,740, she is allowed to retain only the \$70,740 amount. The remaining assets (\$149,260) are considered to belong to Mr. Anderson and he must "spend down" those assets before he can become eligible for Medicaid.

Mrs. Anderson is also allowed to retain a Minimum Monthly Maintenance Needs Allowance (MMMNA). Mr. Anderson's monthly income is \$1,500 and Mrs. Anderson's income, including interest on her CSRA of \$70,740, is \$1,200. They live in a state that has set the MMMNA at the maximum allowable amount of \$1,769. Under the MMMNA provisions, Mr. Anderson is allowed to divert \$569 of his income to Mrs. Anderson, in order to bring her total monthly income up to the MMMNA level of \$1,769.

One strategy that Medicaid estate planning attorneys have used is to *increase* the community spouse's CSRA above the maximum allowable amount through another special provision of the MCCA. This provision states:

"(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE. If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance." 42 U.S.C. §1396-5(e)(2)(c)

Presumably, the intent of Congress in enacting this provision was to allow for circumstances in which couples may have relatively high levels of assets, but combined incomes below the MMMNA. However, estate planning attorneys have used this provision as a loophole to obtain higher CSRA levels for the community spouse.

This is done under another provision of MCCA which states that income from the institutionalized spouse can be used to increase the community spouse's income to the MMMNA, *"but only to the extent income of the institutionalized spouse is made available to the community spouse"* 42 U.S.C. §1396-5(d)(1)(B). The strategy devised by Medicaid estate planners is to use these two provisions of MCCA in concert to increase the CSRA by advising that the institutionalized spouse's income *not be made available to the community spouse*. This strategy is sometimes referred to as the "shift assets before income rule."³⁰

³⁰Woolpert, Mark. "Spousal Impoverishment—Maximizing Asset Preservation: The 'Shift Assets Before Seeking Income Rule.'" *Elder Law Advisory*, Number 2, May 1991.

Exhibit 3 illustrates the effect which the "shift assets before income rule" would have on the hypothetical case described in Exhibit 2.

Exhibit 3

The Effect of the "Shift Assets Before Income Rule"

Mr. Anderson refuses to make any his \$1,500 monthly income available to Mrs. Anderson. Mrs. Anderson's monthly income, excluding interest from assets, is \$914. In order to bring Mrs. Anderson's monthly income up to the MMMNA of \$1,769, Mrs. Anderson's attorney petitions a local court to set aside an additional amount of the Anderson's combined assets sufficient to make up the difference between Mrs. Anderson's income and the MMMNA. This amount equals \$855 (\$1,769-\$914). The petition assumes an annual rate of return of 5.0% on the increased CSRA. The amount of assets needed to generate \$855 in additional income is \$205,200 $(\$205,200 \times 5\%)/12 \text{ months} = \855 . The local court grants the petition, Mrs. Anderson is permitted to retain \$205,220 of the couple's combined assets of \$220,000, leaving Mr. Anderson only \$14,780 in assets of his own which he must deplete down to \$2,000 before he becomes eligible for Medicaid. He does so and becomes eligible for Medicaid within five months of his nursing home admission.

These higher CSRA allocations for the community spouse are generally retained either through a fair hearing process or through a court order. Some attorneys argue that a court proceeding is the preferred strategy because it generally takes less time than a fair hearing process, and because "many courts will have no experience with Medicaid and the relief sought."³¹ Others point out that "[M]any judges simply ask in open court whether or not there is anyone who wishes to object. Generally, since there is no requirement that [Medicaid] be notified, no one objects."³²

Attorneys report success in obtaining higher CSRA allowances with this strategy through fair hearing decisions in California, Connecticut, Indiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Illinois, North Carolina, and Virginia.³³

Other states, as well as HCFA, do not support this interpretation of the MCCA spousal impoverishment provisions. The key issue, clearly, is whether the institutionalized spouse can voluntarily choose not to make his or her income "available" to the community spouse, so that additional assets can be diverted to the community spouse to increase the CSRA. Pending publication of regulations on the MCCA spousal impoverishment rules, HCFA has circulated preliminary guidelines under the State Medicaid

³¹Eakes, M. Garey: *Sophisticated Medicaid Planning and New Developments in Income Cap States: A Panel Discussion*, November 1992.

³²Woolpert, Mark: "Spousal Impoverishment—Maximizing Asset Preservation: The 'Shift Assets Before Seeking Income Rule.'"

³³Eakes, M. Garey, *op. cit.*, and also as reported in "Medicaid Survey Results: Still No Nationwide Standards." *The ElderLaw Report*, Volume III, Number 8, March 1992.

Manual. Although the guidelines acknowledge that a higher CSRA can be substituted for the generally allowed maximum CSRA in order to bring the community spouse's income up to the MMMNA in certain cases, the manual states "[T]here are no substitutions when institutionalized spouses do not make available monthly income allowances to community spouses."³⁴

In accordance with these HCFA guidelines, **Maryland** issued new program regulations in 1992 requiring that the applicant's income be considered first when addressing the adequacy of the community spouse's income. **Connecticut** Public Act No. 92-233 also specifies that no court can allocate a CSRA higher than the maximum amount allowed by the state Medicaid agency "unless (A) such limitations on...property would result in significant financial duress or (B) an amount exceeding such limitations is necessary [emphasis added] to generate income. Although some attorneys were initially successful in obtaining higher CSRA levels using the "shift assets before income rule" in **Oklahoma** through fair hearings, the state has since denied these types of appeals, and attorneys are reportedly now pursuing this strategy exclusively through the courts.

In addition to obtaining higher CSRA amounts, Medicaid estate planning attorneys have also petitioned courts to simply establish a higher monthly income allowance for the community spouse, above the MMMNA in that state. **Connecticut's** new law also prohibits such court orders except in cases that would result in "significant financial duress."³⁵ **Maryland** also made a change to the Family Law Article of the Maryland Annotated Code eliminating the ability of individuals to obtain "alimony" without a divorce, if the grounds for the alimony decree are based solely on residence in a nursing home.

Another strategy employed by the Medicaid estate planning industry is referred to as the "Just Say No" strategy. This strategy exploits a loophole in the Medicaid statutes which has always given states the right to grant Medicaid eligibility to an institutionalized spouse who would be eligible due to excess assets held by a community spouse, but who has been truly abandoned by the community spouse. Some Medicaid applicants have exploited this loophole by invoking this assignment of spousal support provision based upon an alleged "refusal to support" by the community spouse. A survey of Medicaid estate planning attorneys conducted in 1991 indicated that this "Just Say No" strategy has been employed successfully in three states—**New York, Tennessee, and Wisconsin**.³⁶

³⁴State Medicaid Manual, HCFA-Pub. 45-3, § 3262.3, Transmittal No. 39 (Oct. 1989).

³⁵The MCCA language is equivocal on this issue. One section states that if a court has entered an order "against an institutionalized spouse" for a monthly income allowance, then that will be the monthly income allowance. Another provision states that a revision of the minimum monthly needs allowance is only allowable "due to exceptional circumstances resulting in significant financial duress." The first provision would seem to be intended for cases where an institutionalized spouse was refusing to provide for the support of a community spouse.

³⁶"Medicaid Survey Results: Still No Nation-wide Standards." *The ElderLaw Report*, Volume III, Number 8, March 1992. One attorney in New York claimed that the state does not pursue the community spouse for support, except when the amount refused exceeds \$500,000 and in certain counties only.

In response to the "Just Say No" strategy, Maryland stipulated through amended state law and program regulations in 1992 that assignment of spousal rights provisions can only be applied in those situations where it is actually needed to protect the institutionalized spouse. The new law also levies penalties against a community spouse who refuses to pay for his spouse's care. In its review of Medicaid asset transfer policies, the Virginia Joint Legislative and Audit Review Commission also recommended that the General Assembly consider "prohibiting the courts from issuing orders which allow individuals the right to claim the assets of other institutionalized persons without their legal consent for purposes of avoiding payment of medical expenses."³⁷

2.10 Expansions in Estate Recovery Programs

The goals of Medicaid estate planning are not only to make the applicant's assets "unavailable" in the initial determination of eligibility for Medicaid, but to ensure that these assets are never made accessible throughout an individual's participation in the Medicaid program. This includes the objective of ensuring that any property which remains in the estate of the Medicaid recipient after his or her death does not become subject to recovery during probate of the recipient's estate. The response of states has been to improve the effectiveness and efficiency of their estate recovery programs, such that any property which remains in a Medicaid recipient's estate is used to offset the costs which he or she incurred during their enrollment in the Medicaid program.

A recent survey of states to obtain information about their estate recovery programs was recently conducted by the American Public Welfare Association.³⁸ The survey results are presented in Exhibit 4; 25 states plus the District of Columbia report that they have a Medicaid estate recovery program, 23 do not, while New Mexico and Rhode Island did not respond to the survey. Further, of the states which have estate recovery programs, six states also use TEFRA liens as a means to recover Medicaid payments.

Two states, Kansas and Colorado, enacted estate recovery programs in 1992. The estate recovery program in Kansas will recover Medicaid costs incurred after July 1, 1992, and is modeled on the estate recovery program in the state of Oregon, which is widely regarded as one of the most effective estate recovery programs in the nation. Although the Kansas program does not include a TEFRA lien provision, the enabling legislation does specify the state Medicaid program as a "priority claimant" on probated estates, after funeral homes. The legislation also mandates that the program must demonstrate cost-effectiveness in the first year of operation, meaning that amount of funds recovered through estate recovery must exceed the costs of program administration.

Colorado enacted an estate recovery program in October 1991, in the same bill which established criteria under which certain individuals with incomes in the "Utah gap" could become eligible for Medicaid

³⁷ Medicaid Asset Transfers and Estate Recovery. Joint Legislative Audit and Review Commission, Virginia General Assembly, Senate Document No. 10, November 1992.

³⁸ "Estate Recovery Survey Results," American Public Welfare Association, Draft Report, December 1992.



through the creation of "income trusts" (see Section 2.8). The Colorado estate recovery program also includes a TEFRA lien provision, in which a lien will be placed on a Medicaid recipient's primary residence if a determination is made by a Peer Review Organization that the recipient is not likely to return home. The recipient also has a right to appeal the decision of the Peer Review Organization in a fair hearing.

There are two primary advantages of utilizing a TEFRA lien authority in conjunction with an estate recovery program. First, the placement of a lien on a residence increases the likelihood that the Medicaid agency will be notified in case the property is sold, since buyers are unlikely to close on the sale until the lien is resolved.³⁹ Second, it increases the opportunity for states to recover Medicaid costs on property which *does not* pass through probate upon the death of the recipient, for example, property which passes through joint tenancy and rights of survivorship, or property which passes to heirs through various trust arrangements.

In addition to the enactment of new estate recovery programs, other states have implemented changes to strengthen their existing programs, many of which remain largely ineffective in recovering funds from Medicaid recipients' estates.⁴⁰ Based on the recommendations of a Special Commission on Medicaid Estate Recovery, **Massachusetts**, for example, has made a number of improvements to its estate recovery program in recent years.⁴¹ These changes include a statutory amendment requiring the administrators of all probated estates to send a copy of (a) the petition for admission to probate and (b) the decedent's death certificate to the state Medicaid agency. This requirement applies to *all* probated estates, not just those of individuals who have received Medicaid. This information is then cross-checked with Medicaid enrollment files to determine whether the decedent had ever been enrolled in the Medicaid program. This has greatly improved the ability of the state to identify potential estates for recovery.

Other recent amendments include: (1) a provision allowing the state to designate a public administrator to probate an estate in cases where heirs have failed to file a petition to probate (as a means of avoiding estate recovery); (2) a requirement that the state be notified if any real estate is sold while still in probate; (3) a provision for using streamlined procedures in recovering from non-probated estates (generally those below \$15,000); and (4) making the state a "higher priority" claimant on insolvent estates where there are insufficient assets in the estate to satisfy the claims of all creditors.

³⁹If the property is sold, and the Medicaid recipient receives fair market value for the property, the lien will be released, but the recipient is likely to become ineligible for Medicaid as a result of receiving the proceeds from the sale. If the property is sold, and the Medicaid recipient *does not* receive fair market value for the property (e.g. the proceeds of the sale are placed in a trust), then the recipient can be subject to a period of ineligibility for a prohibited transfer.

⁴⁰General Accounting Office, Medicaid: Recoveries From Nursing Home Residents' Estates Could Offset Program Costs, GAO/HRD-89-56, March 1989.

⁴¹Special Commission on Medicaid Estate Recovery: Report and Proposed Legislation, Commonwealth of Massachusetts, November 1991.

The Massachusetts estate recovery program also includes a provision to encourage individuals to purchase private long-term care insurance. This provision stipulates that if an individual purchased and used at least two years of private long term care insurance (with at least a \$50/day benefit) prior to receiving Medicaid coverage, that there will be no recovery from the individual's estate upon their death.

As previously discussed, commissions in both Virginia and Indiana have also recommended improvements in those states' estate recovery programs. One major area of emphasis in enhancing the effectiveness of estate recovery programs is improved methods for identifying real property held by Medicaid recipients, and then tracking the property throughout an individual's enrollment in the Medicaid program, so that Medicaid costs may be eventually recovered upon the individual's death. Another area for improvement is the continued tracking of property that is transferred to a spouse of a Medicaid recipient. This property cannot be subject to recovery as long as the spouse remains in the home, but once the home is sold, or the spouse dies, the state's claim on the property can then be enforced.

The estate recovery program in California was dealt a setback in 1989 when the federal Ninth Circuit Court of Appeals ruled in the case of Citizens Action League v. Kizer, 887 F.2d 1003 (9th Cir. 1989) that California *could not* recover costs from the real property of deceased Medicaid recipients that passed by right of survivorship rather than through probate. The ruling revolved around the language used in TEFRA which established the conditions under which states can recover costs through estate recovery. The language states, "No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except...In the case of any other individual who was 65 years of age or older when he received such assistance, from his *estate*" (emphasis added) 42 U.S.C. § 1396p(b)(1)(B). The court concluded that since Congress failed to specifically define the word "estate" that a common law definition must be used, which only includes property that passes through probate.

California appealed this decision to the United States Supreme Court (No. 89-1056). Although the Supreme Court concluded that "in the absence of a federal limitation on the meaning of 'estate,' California was free to define that term to include property that the deceased beneficiary held in joint tenancy," and that "we believe the case was wrongly decided," it denied California's petition for a writ of certiorari, because the case lacked "national significance." The Supreme Court believed that a clarification of the definition of "estate" in either Medicaid regulation or amended Medicaid statute was the proper recourse in this case. However, such recourse has not been forthcoming either in Medicaid regulation or statute since then, and California has been forced to terminate recoveries of property passed to joint tenants through rights of survivorship, resulting in an overall decline in the amount of Medicaid costs which California has been able to recover since the Ninth Circuit Court of Appeals' ruling.

CHAPTER 3

CONCLUSIONS

As the level of Medicaid estate planning activity has increased in recent years, it is apparent that states are becoming increasingly aware of the need to implement policy responses to limit its practice. Regardless of the impact which Medicaid estate planning may be having on current Medicaid outlays, states recognize its potential impact on future expenditures, if not brought under control. This report discusses numerous initiatives among states to enact and implement new policies to limit the ability of elderly individuals to shelter or divest their assets without incurring penalty periods of ineligibility. States are also implementing policies to improve the effectiveness of their estate recovery programs, so that assets remaining in a Medicaid recipient's estate upon death can be recovered to offset costs incurred while the recipient was receiving Medicaid assistance for his or her nursing home care.

However, it is also apparent that many states are unclear about the constraints of current Medicaid law on their efforts to restrict Medicaid estate planning activity. Some states are uncertain about whether their actual or contemplated policy responses to Medicaid estate planning are or are not in compliance with Federal Medicaid law, and HCFA's interpretation of Federal law. Some states are more risk averse than others, and will not implement new policies without unequivocal authorization from HCFA. Even with such authorization, it is interesting that some states still display reticence to implement changes. For example, even though HCFA has issued guidelines to states which support imposing consecutive rather than concurrent penalty periods for multiple transfers, some states still elect to apply concurrent rather than consecutive penalties.

In addition, Federal Medicaid law provides very little guidance on how states can address other planning strategies. For example, the treatment of irrevocable annuities as a Medicaid estate planning tool is not addressed at all in Federal Medicaid law, and states have developed their own innovative approaches to applying transfer of asset provisions to their purchase. Similarly, the enactment of the Medicaid spousal impoverishment provisions under the Medicare Catastrophic Coverage Act created a number of opportunities for Medicaid applicants and their attorneys to shift resources between spouses in a manner that maximizes protected resources and minimizes transfer of asset penalties, and states have had to address these Medicaid estate planning techniques with little Federal guidance.

States expressed a strong desire for Federal clarification on Medicaid transfer of asset provisions to support their efforts to restrict Medicaid estate planning practices. Although the Medicare Catastrophic Coverage Act was enacted almost five years ago, the government has still not issued even preliminary regulations on either the spousal impoverishment provisions of the Act, or the transfer of asset provisions. The timely issuance of these regulations would clearly be most welcomed by state Medicaid programs.

However, states also expressed the need for additional Federal legislation to comprehensively address Medicaid estate planning as a policy problem. There are several areas where legislative, rather than regulatory, clarification appears warranted. One issue that needs to be addressed through new legislation is asset transfers conducted through joint bank accounts. Current law, as it applies to those states which follow SSI eligibility rules, appears to restrict the ability of states to impose periods of ineligibility on these types of transfers, even though they clearly involve the transfer of resources for less than fair market value from applicants to non-applicants.

Another issue needing legislative change is in setting the start date for a period of ineligibility for a prohibited transfer, since the MCCA clearly states that the period of ineligibility begins on the date of the transfer, *not* the date that the applicant would have otherwise been eligible for Medicaid in a nursing home.

At the time of this writing, the President has submitted a proposal to Congress as part of his FY 1994 budget to enact a series of restrictions to close eligibility loopholes and restrict Medicaid estate planning devices. The proposed legislation:

- Further restricts the use of trusts as a strategy for sheltering assets. All assets within an irrevocable trust are considered available to the applicant if the applicant is a beneficiary of the trust in any manner.
- Clarifies the definition of "estate" for the purposes of estate recovery programs in a manner which overcomes the opinion of the Ninth Circuit Court of Appeals in Citizens Action League v. Kizer.
- Extends the period of ineligibility to as many months of nursing home care that could have been paid for with the transferred assets, rather than limit the period of ineligibility to 30 months (although transfers made prior to 30 months of Medicaid application would remain exempt from penalties).
- Changes the start date for periods of ineligibility to the date on which the person would have otherwise been eligible for Medicaid in a nursing home.
- Limits the amount of assets that can be retained by a community spouse to the maximum amount allowed under the state Medicaid plan.
- Applies transfer of asset penalties to transfers made through joint ownership, including joint bank accounts.

Should this legislation be enacted by Congress as part of this year's Omnibus Budget Reconciliation Act, it would have a significant impact on restricting the ability of individuals to shelter or divest their assets in order to gain public assistance for their nursing home care.

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